AUTHORIZATION FOR UTAH STATE HOSPITAL TO DISCLOSE PROTECTED HEALTH INFORMATION

Return Address: Medical Records Department, Utah State Hospital, P.O. Box 270, Provo, UT 84603-0270
Phone: (801) 344-4289 Fax: (801) 344-4223

This allows Utah State Hospital to disclose the health information that is protected by federal health privacy laws. Utah State Hospital will not release your protected health information unless the privacy laws require or permit us to do so, OR unless you instruct us to do so.

Patient Name: _____ DOB: _____

Address: _____ SSN: _____

_____ Phone #:_____

I am: ❑ the individual named above.
❑ the individual's legally authorized representative/guardian.

The Utah State Hospital has my permission to disclose protected health information to:

Name: _____ Organization: _____

Address: _____ Relationship: _____

_____ Phone #:_____

Please indicate below which information you would like disclosed. Other information must be specifically identified. Requests for disclosure of "any and all" information will not be honored:

____ Discharge Summary
____ HIV / AIDS Related Information
____ Labs
____ Psychiatric Assessment
____ Individual Comprehensive Treatment Plan (ICTP)
____ Physical Examination
____ Psychological Assessment
____ Social History
____ Substance Abuse Treatment Notes

Other: _____
_____
_____
_____
_____
_____

____ Verbal Communication (please indicate below which topics you authorize for discussion):

___ Admission Information
___ Current Condition, Physical and Mental
___ Financial Information
___ Individual Comprehensive Treatment Plan (ICTP)
___ Medications
___ Other: _____
___ Diagnosis
___ Discharge Plan/Issues
___ Incidents (injury, seclusion/restraint)
___ Legal Status
___ Treatment Needs/Issues

____ Mailing the Hospital Orientation Manual, Newsletter and Family Satisfaction Questionnaire

Please list any limitations: _____

_____

Please include records from _____ (date) to _____ (date).

The purpose of this disclosure is: _____

This Authorization expires on the following date or event: (one of the following must be selected)

- ❑ **Discharge from Utah State Hospital,**
- ❑ **Other Event or Date: _____, or**
- ❑ **90 days from the date of signature if no other date or event is indicated.**

- I understand that I have the right to revoke this Authorization in writing at any time by submitting a letter of revocation to the Medical Records Department. I understand that some disclosures may have been made before revocation.
- I understand that I may refuse to sign this Authorization, and Utah State Hospital can not refuse to provide treatment, payment or deny eligibility for benefits based upon my refusal.
- I understand that if the persons or agencies authorized to receive this information are not health plans or health care providers, the released information may no longer be protected by federal privacy laws and they may re-disclose it to someone else.

Signature of Patient: _____ Date: _____

This section to be completed if authorization is being given by Guardian/Personal Representative:

❑ I am legally authorized to make healthcare decisions on behalf of this individual.

Legally Authorized Representative Signature: _____ Date: _____

Please Print Name: _____

Representative's Authority to act on behalf of the individual: _____

RECIPIENT INFORMATION: If the information released related to substance abuse treatment, the records are protected by federal confidentiality laws and you are prohibited from making further disclosures of this information without the specific written authorization of the person to whom it pertains or as permitted by 42 CFR Part 2. A general authorization for the release of information is NOT sufficient for this purpose. Federal law restricts using this information for criminal investigation or prosecution.